Exhibit 1

MH#3569976
VH#35634997
VH#35890193
969 pgs

AFFIDAVIT OF CUSTODIAN OF MEDICAL RECORDS

a) I am the duly authorized Custodian of the medical records of Williamson Medical Center and have the authority to certify said medical records.

b) The copy of the medical records on Galuten, Hortense are true copies.

c) The records were prepared by the personnel of the hospital, staff physicians, or persons acting under the control of either the hospital personnel or staff physicians in the ordinary course of the hospital's business at or near the time of the act, condition, or event reported therein.

SWelch HIM coordinator
Director, Health Information Management

6/15/18
Date

STATE OF TENNESSEE

COUNTY OF Williamson

Subscribed and sworn to before me, a notary public in and for said county, this 15 day of June 2018.

BETTY LEBLANC STATE OF TENNESSEE NOTARY PUBLIC WILLIAMSON COUNTY

Betty Leblanc
Notary Public

My commission expires: 10-17-21

GALUTEN , HORTENSE 356976
Visit # 35890193

ADMISSION DATE: 06/02/2016
DISCHARGE DATE: 06/11/2016

PRIMARY CARE PROVIDER:
None.

ADMISSION DIAGNOSES:
1. Severe hypernatremia due to dehydration.
2. Decreased oral intake.
3. Malnutrition.
4. CKD stage IV.
5. Leukocytosis.
6. Hemoconcentration.
7. Hypertension.
8. Lewy body dementia.
9. Possible parkinsonism.

DISCHARGE DIAGNOSES:
1. Acute renal failure due to pancreatitis and hypotension.
2. Pancreatitis, resolved.
3. Hyperkalemia presumed to be due to aggressive oral supplementation and renal failure, resolved.
4. Metabolic encephalopathy.
5. Hypernatremia due to dehydration, resolved.
6. Dehydration, resolved.
7. Hypocalcemia, resolved.
8. CKD stage III.
9. Constipation, chronic.
10. Lewy body dementia.
11. Failure to thrive.
12. Coffee-grounds emesis.
13. Severe protein calorie malnutrition.

Co-E/S:

E/S: BENSON,LEVI POTTER
<Electronically signed by LEVI P. BENSON MD>
06/11/16 1831

Name: GALUTEN,HORTENSE S
MR: M000356976
Admit Date:06/02/16
Acct: V00035890193
DOB: 08/18/1922
Room No: 341-A

CONSULTATIONS:
Gastroenterology and nephrology.

PROCEDURES:
1. Chest x-ray on 06/03 showed a left upper extremity PICC line projecting its tip into the SVC. Mild interstitial scarring accentuated by hypoventilatory change.
2. Left knee x-ray showed mild osteoarthritis.
3. Right knee x-ray showed mild osteoarthritis.
4. Pelvis x-ray showed mild osteoarthritis of the hips without evidence of fracture or dislocation. Diffuse osteopenia.
5. Right femoral vas cath placement on 06/06.
6. CT abdomen and pelvis with contrast on 06/06 showed moderate intra-abdominal ascites with fluid also seen surrounding the pancreas. Correlation with amylase and lipase level is recommended to exclude pancreatitis. No pseudocyst or abscess. Bilateral pleural effusions with dependent consolidation either pulmonary edema or pneumonia. Consider aspiration. Nonspecific enhancement of the wall of the gallbladder. No radiodense gallstones. Correlate with clinical symptoms of cholecystitis. Large amount of proximal colonic stool predominantly within the cecum and transverse colon. Constipation to be considered.
7. Gallbladder ultrasound on 06/06 showed no evidence of gallstone. Biliary sludge in the gallbladder without biliary dilatation. Complex appearing pericholecystic fluid. Gallbladder wall is at the upper limits of normal thickness measuring 3.4 mm. Edematous pancreas with peripancreatic fluid consistent with pancreatitis demonstrated on prior CT. Mild ascites in the upper abdomen. No evidence of a focal drainable fluid collection.
8. Chest x-ray on 06/11 showed findings compatible with pulmonary edema with stable interstitial changes; however, moderate right pleural effusion has increased. Stable mild to moderate left pleural effusion.

HISTORY OF PRESENT ILLNESS:
The patient is a 93-year-old female with a history of presumed Lewy body dementia, who presented to the hospital originally because of lack of oral intake as well as generalized decline. She had suffered a fall at home as well. She was found to have a sodium of 161 at presentation with a creatinine of 1.5. She was admitted.

HOSPITAL COURSE:
The patient originally did fairly well. She was fluid resuscitated with normal saline. Notably, she was not hypotensive at presentation. Lab evaluation again at presentation showed a sodium of

161 with a creatinine of 1.5 and calcium 10.8. LFTs were normal. She was somewhat hemoconcentrated at presentation with a white count of 15.1 and hematocrit of 48.6. Gastroenterology was consulted at the son's request for consideration for a PEG tube placement for hyperalimentation at home due to poor oral intake at home. There were plans made for this. In preparation for the procedure, the patient's son reportedly had the patient _____ and two full trays within one day. Shortly after that, the patient developed worsening abdominal pain and some relative hypotension with systolics dropping into the 80s. She also subsequently developed hyperkalemia with potassium peaking at 8.1. Creatinine increased to 2.3 and calcium dropped to 4.6 with an ionized 9 calcium of 2.5. The patient was transferred to the ICU. Urgent nephrology consultation was called and a vas cath was placed and dialysis pursued. The patient tolerated dialysis well and required I believe only one dialysis session. Renal function has subsequently recovered and potassium improved. The patient's mental status waxed and waned while here which was felt to be due to the hospital-based delirium as well as pain medications. She did have what appeared to be some mild coffee-grounds emesis; however, her hematocrit remained stable. She was placed on a PPI. Ultimately the patient as mentioned did improve. She developed some mild pulmonary edema; however, this was felt to be due to her poor nutritional state. Lasix was not aggressively pursued due to her presentation with dehydration. The patient was felt to be debilitated and that she would benefit from SNF. The patient's son was in full agreement with this. On the day of discharge she was quite looking forward to SNF placement. She had a bed at Somerfield and the patient was subsequently transferred.

DISCHARGE PHYSICAL EXAMINATION:
VITAL SIGNS: Temperature 98.6 degrees Fahrenheit, blood pressure 126/66, pulse 89, respirations 22, O2 sat 100% on 2 liters nasal cannula.
GENERAL: Pleasant Caucasian female lying in bed in no acute distress. She is confused.
HEENT: Mucous membranes moist.
CARDIOVASCULAR: Normal rate, regular rhythm, no murmurs, rubs or gallops.
PULMONARY: Lungs are clear except for some very mild crackles at the bases.
ABDOMEN: Soft, nontender, nondistended.
EXTREMITIES: No edema.

DISCHARGE DIET:
Regular. She has a 1250 kilocalorie per day requirement.

DISCHARGE ACTIVITY:
As tolerated.

Co-E/S:

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DISCHARGE MEDICATIONS:
1. Vitamin D3 weekly.
2. Multivitamin every other day.
3. Sinemet 25/100 mg 1 tab p.o. t.i.d. a.c.
4. Lasix 20 mg p.o. daily.
5. Protonix 40 mg p.o. b.i.d., which is new.
6. Zofran 4 mg sublingually q.4 h. p.r.n., which is new.
7. Docusate 100 mg p.o. b.i.d. which is new.

FOLLOWUP:
The patient is being discharged to Somerfield. She has no PCP in the area. She should have a BMP checked 2 days after discharge. She also should have a CBC checked 2 days after discharge.

Total discharge time spent with this patient was 38 minutes.

LB/LB/zb/001129
D: 06/11/2016 15:17:02
T: 06/11/2016 17:29:11 Levi Benson, MD

cc:

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